CERTIFICATION BY OFFICER OR ADMINISTRATOR

Medicaid Provider No. 0
Period: From 01/00/00
To 01/00/00

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medical Assistance Program Universal Cost Report for the period ended 01/00/00 and that, to the best of my knowledge and belief, they are true, correct and complete statements prepared from the books and records of 0 (Provider Name), in accordance with applicable program directives, except as noted.

(Signed) _____
Officer or Administrator

_____
Title

_____
Date

PROVIDER CONTACT AND/OR DESIGNEE

Name: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Corporate owner under name other than PCC or RHC:
(i.e., name of hospital that owns entity) _____

Corporate Contact: _____